

## TRANSPORT **SUPERVISION** INFORMATION CHECKLIST FOR PERSONS ON INVOLUNTARY STATUS

Name of individual for Service: \_\_\_\_\_ DOB \_\_\_\_\_  
Designated Agency \_\_\_\_\_ Name of QMHP: \_\_\_\_\_  
TRANSPORT: Transported from: \_\_\_\_\_ Transported to: \_\_\_\_\_  
SUPERVISION: Emergency Department: \_\_\_\_\_  
Time and Date of LAST Assessment: \_\_\_\_\_ Time and Date of Transport \_\_\_\_\_

*Pursuant to 18 V.S.A. §7511, secure transport and escort shall be done in a manner which prevents physical and psychological trauma, respects the privacy of the individual, and represents the least restrictive means necessary for the safety of the patient. It is the policy of the state of Vermont that mechanical restraints are not routinely used on persons who are receiving treatment involuntarily unless circumstances dictate that such methods are necessary.*

Observation period prior to transportation decision may be used but should NEVER delay transport.  
Individual and/or family preference will be considered and accommodated, if possible, for mode of transport.

**Emergency Department Supervision is to be provided by DMH-contracted providers or designees and is ordered exclusively by Admissions at VPCH 802-828-2799**

### **Considerations in Determining Mode of Transportation and safety of Supervision:**

1. What is the client's history of behavior? ☐ cooperative ☐ unwilling ☐ triggering  
☐ unknown?
2. Have the client's friends/family been consulted regarding service options? ☐ No ☐ Yes
3. Has the client been consulted regarding service options? ☐ No ☐ Yes
4. Is the client able to regulate his or her behavior? ☐ No ☐ Yes client approachable to discuss options? ☐ No ☐ Yes
5. Any adverse events in last 24 hours of which transporters ought to be aware? ☐ No ☐ Yes
6. Does client's mood seem stable and sustainable for the length of service ordered? ☐ No ☐ Yes
7. TRANSPORT ONLY: If client was given PRN medication in the ED, have you discussed whether medical monitoring via ambulance would be necessary? ☐ No ☐ Yes

**Please provide any behavioral information that will enhance rapport building between the client and his/her transport team or supervision team in this box:**

**Signatures REQUIRED on back: OVER ►**

**Mode of Transportation RECOMMENDED by QMHP or ED STAFF:**

<b><u>Vehicle</u></b>	<b><u>Accompaniment</u></b>	<b><u>Restraints</u></b>
<input type="checkbox"/> Private transport	<input type="checkbox"/> friend/family	<input type="checkbox"/> None
<input type="checkbox"/> Mental health van alternative	<input type="checkbox"/> mental health staff	<input type="checkbox"/> Metal
<input type="checkbox"/> Unmarked alternative escort	<input type="checkbox"/> support specialist	<input type="checkbox"/> Soft
<input type="checkbox"/> Ambulance	<input type="checkbox"/> sheriff in vehicle	
<input type="checkbox"/> Sheriff's cruiser	<input type="checkbox"/> Other: Peer, advocate etc	
<input type="checkbox"/> Other _____	_____	

**Team Signatures**

Sign: \_\_\_\_\_ PRINT \_\_\_\_\_

☐ Signature of Qualified Mental Health Professional/Designated Professional

Phone contact info (REQUIRED): \_\_\_\_\_

\_\_\_\_\_  
☐ Signature of ED MD

\_\_\_\_\_  
☐ Signature of receiving transport specialist

Please Print Name: \_\_\_\_\_ Please Print Name: \_\_\_\_\_

*Signatures required if parties are involved in assessment of transport needs/outcomes.*

► Provide this form (both sides) to: ☐ Transporter, supervision staff, or mental health transport specialist, and

☐ DMH: Pamela Shover (fax 802-241-0100)

**\*\*Original will accompany emergency exam papers. QMHP will keep a copy of this form for their records\*\***